WHAT YOU NEED TO KNOW ABOUT

YOUR MANAGED CARE HEALTH PLAN

STATE OF CONNECTICUT

OFFICE OF MANAGED CARE
OMBUDSMAN

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(866) HMO-4446

UNDERSTAND YOUR HEALTH PLAN

A growing number of Connecticut's insured citizens get their health care through some form of managed care plan - either you have an HMO, a PPO or a POS plan. Understanding the coverage that your health plan offers you is very important - especially before you need it.

This guide will help you navigate the managed health care system, understand your coverage, know what you need to do when a problem occurs and how to start an appeal in times of dispute. There are many different types of health plans available, and the information in this booklet may not apply to all plan types. This guide is generally not applicable for resolving disputes if you have traditional Medicare or Medicaid coverage.

The **Office of Managed Care Ombudsman** is here to help you understand your rights and responsibilities as a member of a managed care plan. If you have questions about your health plan or need assistance with an appeal, we can help!

www.omc.state.ct.us

KNOW YOUR COVERAGE

Disputes between you and your managed care plan can occur because you may not have a clear understanding of how your managed care plan works, which procedures are covered and what you must do to ensure that benefits will be paid. You need to understand this information BEFORE a problem arises.

There are many different types of health plans and it can get complicated. You probably received a "*Summary of Benefits*" when you enrolled in your plan. It discusses co-payments and covered services. Services nor covered, or excluded, are usually listed in a separate section.

Never assume you have coverage for all services.

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KNOW YOUR COVERAGE

If your health benefits are offered through your employer, you need to know if it is a "*self-insured*" plan. Self-insured plans are exempt from Connecticut state law by the Employee Retirement Income Security Act of 1974 (known as ERISA). This means that the state laws you may hear about do not apply to your health plan. If you are in a self insured plan, request a copy of the plan document through your plan administrator or human resource department.

If you are enrolled in a "*fully insured*" health plan, all Connecticut state laws do apply to you.

Contact your employer's human resources department to determine if your plan is self-insured or fully insured.

KNOW YOUR COVERAGE

Knowing your coverage will help avoid misunderstandings. Review your plan documents and make sure you know about the following:

My plan type is:
- ❑ HMO (health maintenance organization)
- ❑ POS (point-of-service)
- ❑ PPO (preferred provider organization)
- ❑ Other _____

I needed to choose a Primary Care Physician (PCP) when I signed up with this plan:
- ❑ Yes
- ❑ No

I need a referral from my PCP for:
- ❑ Lab & x-ray tests
- ❑ Specialist visits
- ❑ Surgery
- ❑ Mental health services

My PCP can refer me to specialists who:
- ❑ I do not need a referral
- ❑ are on the health plan network list
- ❑ are outside of the health plan network
- ❑ are outside of the health plan network only if there are no similar specialists within the network

I have reviewed the Exclusions and Limitations in my policy and my coverage will not pay for or limits the following services:

_____
_____

I can use the following hospitals:

_____
_____

There is a maximum amount that I can use for out-of-network services:
- ❑ annual _____
- ❑ lifetime _____

If I use out-of-network providers (POS or PPO plan), I will pay: a $ _____ annual deductible and: _____% coinsurance for charges exceeding the deductible.

WHEN YOU HAVE A PROBLEM

Disagreements with health plans arise about which services are covered, what treatments should be followed, which providers should be used, how much a service should cost.

When you have a disagreement with your health plan, your first step be to contact your plan's customer service center. The toll free telephone number is usually on the back of your membership ID card.

Although many disagreements will be resolved at this level, it may be just the first step in the process - so start your record keeping immediately.

- Keep all paperwork.
- Write down all phone calls, the person you spoke to, the date and keep notes.

Always know that the **Office of Managed Care Ombudsman** is here to help you if you have questions!

www.omc.state.ct.us

THE APPEAL PROCESS

If the problem can't be resolved over the telephone, your next step is to begin the appeal process. When you file a formal complaint, it is called an "*appeal*." This means that you are requesting your managed care company to review your situation or denied service again - you are appealing their decision.

Managed care companies in Connecticut are required to have at least two levels of internal appeals. You must first complete Level I, and if the managed care company denies that, then you can begin Level II.

If your health would be seriously jeopardized by waiting for a standard appeal, you may be eligible for an emergency appeal or an "Expedited Review". Your doctor can help you – let us know if you need assistance.

FIRST LEVEL APPEAL

- Initiate verbally (over the phone) by contacting a customer service representative of your health plan. You must say that you want to "*initiate an appeal*." Do not delay this step.
- Written documentation to support your verbal appeal can be sent after your phone call. Encourage your doctor to write a letter supporting your appeal. Always keep a copy of everything you send.
- Your managed care company has 30 business days to make a decision. Call them if you have not received a reply.

Let us help you write your appeal letter - call us!

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THE APPEALS PROCESS

If you are not satisfied with the decision on the Level I appeal, you have the right to initiate a Level II, or grievance, appeal.

SECOND LEVEL APPEAL

- Must initiate in writing. Use the phrase "I wish to initiate a grievance appeal."
- Submit any new information that was not available at Level I.
- You have the right to make an appearance at the grievance hearing (in person or by conference call). This can be extremely beneficial for your case.
- Your managed care company has 30 business days to make a final determination.

You may have to file your grievance within a specified period of time - make sure you read all the documentation you receive from your managed care health plan.

Always contact the **Office of Managed Care Ombudsman** for assistance.

www.omc.state.ct.us

WHAT TO INCLUDE IN YOUR APPEAL LETTER

- Your name, address, telephone number.
- Your member ID number or Social Security number.
- Your doctor's name.
- Description of the service or procedure that you want covered (for a coverage complaint).
- Information supporting why the service should be covered (for a coverage complaint) or why the procedure is necessary.
- Recommendations and referrals from the treating physician regarding why the treatment or procedure is necessary.
- This is your opportunity to explain your situation. We can help you!

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EXTERNAL APPEAL

The State of Connecticut offers an "external review" program through the Connecticut Insurance Department. You become eligible for this program once you have completed all the steps in your health plan's "internal grievance" process. The external review program provides an unbiased way to resolve disputes between patients and their managed care plans and is conducted by health care professionals who are not part of your health plan. External review is offered to those who have exhausted the internal process and who are members of fully-insured plans.

Let's face it, managed care is complicated. Always ask questions when you don't understand your coverage or when you need to appeal a decision made by your health plan.

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